State OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Dental Services

Dental services performed in the office or hospital setting are reimbursed using a fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and a conversion factor (CF). The CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

The fee schedule is maintained in the agency computer database.

A. Development of the Relative Value Units

OHCA staff and a panel of external dentists developed the RVU weights in 1997. Approximately 600 codes representing services in the dental fee schedule were used to establish the weights. All dental services were ranked according to the resources used in furnishing a service. The Oklahoma State and Education Employees Group Insurance dental fee schedule was also used as a data source. Annual dental exam was chosen to have an RVU weight equal to 1.00, and the respective RVUs for the remaining services were developed accordingly. The final weights for each can be found in the agency library.

B. Establishment of the Conversion Factor

To calculate the CF, staff determined the 1996 historical payment and utilization levels for each service. For purposes of the amendment, the conversion factor is $16.48.

C. Updates to the RVUs and CF

The RVUs and CFs will be periodically reviewed and adjusted as deemed necessary by an internal review committee. Providers will be notified of these changes by provider letter.

Oklahoma 7-2-98 9-23-98 6-24-98 98-11

Revised 06-24-98

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Supersedes TN# 86-8

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Payment of Transportation Services

Payment is made for the least expensive means of transportation commensurate with the patient's needs. Transportation and subsistence (room and board) are payable for an escort when authorized and required to meet the patient's needs to obtain medical treatment. Unless otherwise specified, rates are established through a rate review committee, which also allows a public hearing process. Adjustments to the rates will be considered on a periodic or as needed basis as requested by medical providers when supported by a statement explaining the circumstances that cause the existing rate to be inadequate.

(a) **Bus, Taxi or other public carrier:** Payment is made at the public carrier rate.

(b) **Private Automobile:** When transportation is authorized or approved, payment shall be made on a mileage basis. For purposes of this amendment, the mileage rate is 31 cents per mile.

(c) **Air Ambulance or Helicopter:** Payment is made to and/or from a medical facility when other available transportation does not meet the medical needs of the individual. Reimbursement for emergency ambulance transportation is based on a 1986 statewide procedure-based reimbursement system established by the state. The rates are fee schedule data based. The records of these rates are maintained in the agency library. These rates are then published in the document and maintained in our Medicaid fee schedule and on our computer data base.

(d) **Airplane Travel:** Prior authorization is required for commercial airline transportation. The use of airline accommodations may be authorized or approved when the individual's medical condition is such that transportation out-of-state by commercial airline is required. Officials authorizing travel by commercial airline will require the most economical fare be used to the maximum extent possible.

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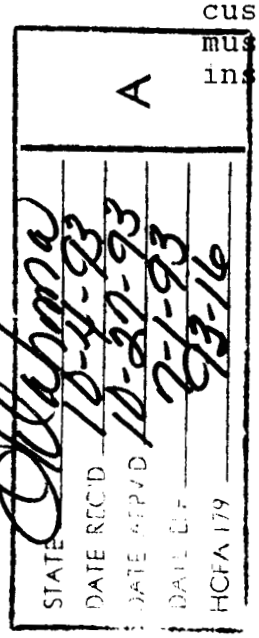
6. Payment for prescribed drugs

Payment for compensable drugs is made on the basis of the lowest of the following:

(1) Maximum Allowable Cost (MAC), for state selected products plus a dispensing fee. The State Maximum Allowable Cost (MAC) is established for certain products which have an approved generic equivalent. The products and MAC price are established based upon the recommendation of a special committee consisting of representatives from the Medical, Osteopathic and Pharmaceutical Associations. The price is set as a percentile of the available medication specific products. Brand necessary exception identified in Section (2) below does apply to State MAC.

* (2) Payment will be made for multiple source drugs identified by HCFA within federally established upper limits. An exception to the HCFA upper limits will be made on brand name drugs that have been certified as medically necessary by a physician for a particular patient. If a physician certifies that a particular brand of Health Care Financing Administration (HCFA) Upper Limit product is medically necessary for the well being of the patient, the maximum reimbursement for the product's ingredient cost will be the Estimated Acquisition Cost (EAC) price or usual and customary charge to the general public. Certification procedures must conform with the following recommendations and/or instructions.

- The certification must be written in the physician's handwriting.
- Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.
- A standard phrase indicating the need for a specific brand is required. Recommend use of the phrase "Brand Necessary".
- The printed box on the prescription blank that could be checked by the physician to indicate brand necessary is unacceptable.
- A hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription is unacceptable.



* Implemented 10-29-87 in accordance with Federal Regulations.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Programming has been developed to review the HCFA upper limit products to assure in the aggregate Medicaid expenditures for multiple source drugs do not exceed the federal upper limits. Such reports and all other relevant statistical data are maintained by DHS and available on request.

(3) The Estimated Acquisition Cost (EAC) as established by the State plus a dispensing fee. The EAC to be used for the purchase of prescription drug products is established at a percentage of the Average Wholesale Price (AWP) as defined by the American Druggist Blue Book. The Rates and Standards Committee of the Department of Human Services after public hearings and submission of evidence has approved AWP -10.5% as the EAC.

(4) The provider's usual and customary charges to the general public.

After public hearings which considered dispensing fee surveys, usual and customary charge surveys and appropriate inflationary indices, the OHCA's Rates and Standards Committee has approved a maximum dispensing fee not to exceed $4.15.

Claims processed through the MMIS will assure the following:

- Eligibility of patient
- Eligible prescriber
- Eligible participating pharmacist
- Compensability of drug
- Cost within limits
- Limit of prescriptions per month

STATE Oklahoma DATE REC'D 11-21-95 DATE APP'D 05-02-96 DATE EFF 10-01-95 HCFA ID 95-19	A

Corrected
Attachment 4.19-B
Page 8

State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

7. Payment for psychological services

Payment is made for psychological services on behalf of eligible individuals under 21 years of age through EPSDT.

Effective for services provided on and after December 1, 1992, payment for physician care, services and supplies is made in accordance with the Medicare Physician Payment Reform Methodology. Reimbursement rates are established at 75 percent of the Medicare allowable. This methodology does not apply to rates for anesthesia services, obstetrical services for delivery, antepartum and postpartum care and EPSDT screenings. Rates for anesthesia services, obstetrical services for delivery, antepartum and postpartum and EPSDT screenings are set in accordance with the statewide procedure based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits per procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS of Medicare was used as an initial base. Comparable procedures were then subjected to procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to payment limits on an individual procedure will be considered by the Procedure Review Committee on a periodic or as needed basis or as requested by medical providers.

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DATE EFF 12-1-92	
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

8. Payment for blood and blood fractions

Inpatient - Payment is made to blood banks for blood or blood fractions used for inpatient care when the cost of blood is not included in the per diem cost of the hospital.

Outpatient - Payment is made to a physician, clinic, outpatient hospital or blood bank for blood and/or blood fractions when these products are required for the treatment of a congenital or acquired disease of blood. Claims for blood are screened through the regular computer stream against eligibility files to assure that no payment is made beyond the scope of the program.

Effective for claims filed on and after April 1, 1986 payment for care, services and supplies is made in accordance with the statewide procedure-based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits for each procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS or Medicare was chosen as an initial base. Comparable procedures were then subjected to a procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to the payment limits on an individual procedure will be considered by the Procedure Review Committee on a periodic or as needed basis as requested by medical providers. The payment will not exceed the total allowable amount for comparable services under comparable circumstances under Medicare in the aggregate.

STATE OK
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DATE APP'VD 3-2-87
DATE EFF 4-1-86
HCFA 179 86-8

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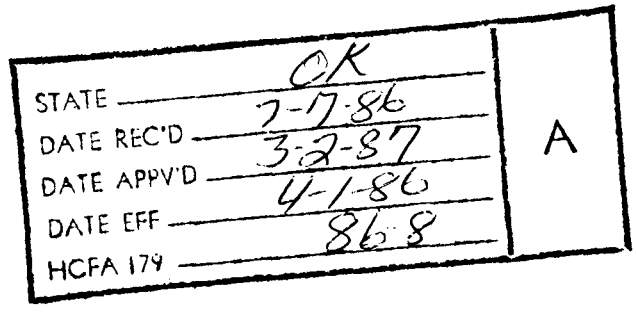
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

9. Payment for other services and supplies

Effective for claims filed on and after April 1, 1986 payment for care, services and supplies is made in accordance with the statewide procedure-based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits for each procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS or Medicare was chosen as an initial base. Comparable procedures were then subjected to a procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to the payment limits on an individual procedure will be considered by the Procedure Review Committee on a periodic or as needed basis as requested by medical providers. The payment will not exceed the total allowable amount for comparable services under comparable circumstances under Medicare in the aggregate.



**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE**

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10. Payment for non-technical medical care (personal care service in own home)

When personal care service in own home is provided by an individual who is not employed by a home care agency, the method and policy utilized for the periodic rate adjustments will be tied to the annual cost of living index and inflation factors and initiated upon recommendation by the Medical Advisory Committee through the Director and approved by the Commission for Human Services. The payment is a per diem rate to providers less the F.I.C.A. tax. In accordance with policy established July 1, 1973, DHS pays the provider/employee and recipient/employer share of F.I.C.A. tax to the Internal Revenue Service.

When personal care service in own home is provided by a home care agency, the rate paid to the agency is an amount equal to the wage paid to the individual personal care provider plus an additional amount necessary to cover additional administrative expenses incurred by the agency in the provision of the service. These expenses are not incurred by the individual provider since they are functions provided by the Department for the individual provider.

STATE Oklahoma
DATE REC'D 10-03-94
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DATE EFF 07-01-94
HCFA 179 94-18

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

11. Payment for nurse-midwives

Payment is made to certified nurse-midwives for obstetrical care.

Effective for claims filed on and after April 1, 1986 payment for care, services and supplies is made in accordance with the statewide procedure-based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits for each procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS or Medicare was chosen as an initial base. Comparable procedures were then subjected to a procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to the payment limits on an individual procedure will be considered by the Procedure Review Committee on a periodic or as needed basis as requested by medical providers. The payment will not exceed the total allowable amount for comparable services under comparable circumstances under Medicare in the aggregate.

STATE OK	A
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HCFA 179 86-8	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Description of How Rates are Set for Residential Psychiatric Treatment Centers

Effective July 1, 1991, reimbursement for residential psychiatric treatment centers is paid on a prospective per diem system. There are two distinct payment components under this system. Total per diem reimbursement under the new reimbursement system will equal:

A facility-specific per diem operating and movable capital amount

+

A blended per diem fixed capital amount

The second component, the per diem capital component, is calculated as a blend of a facility-specific fixed capital per diem and a statewide median fixed capital per diem. This blend will be phased-in over a three year time period.

Blend 1:

25% of the Statewide Median Per Diem

+

75% of the Facility-Specific Per Diem

Blend 2:

35% of the Statewide Median Per Diem

+

65% of the Facility-Specific Per Diem

Blend 3:

50% of the Statewide Median Per Diem

+

50% of the Facility-Specific Per Diem

STATE	Oklahoma
DATE REC'D	4-30-91
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DATE EFF	7-1-94
HCFA 179	91-12
	A